"Medical and social advances toward substituting treatment for the punishment of problem drinkers have not been matched in politics and in law."

Legislation and Alcoholism

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THE report of the Committee on Public Health of the New York State Bar Association (*1*) points up again the legal implications of public health practice applying to alcoholics. In understanding alcoholism, great progress has been made in the last 15 years. The affliction, now considered a major health problem, it is felt, can be treated successfully in many instances. Differences as to its nature and treatment do not prevent the accumulation of a body of knowledge which will help restore to health many whose lives are threatened by this disease. We must frankly concede that we do not know all the answers, but we have indications that we can find the right track.

We are learning to distinguish between alcoholism and problems associated with drinking that may be merely casual however toxic may be the concentration of alcohol in the blood. Such a distinction is essential if the courts, the physicians, and the social services are to prescribe appropriate treatment. There is no blanket definition, diagnosis, or treatment to be applied to people who drink "too much"; people who drive a car with a few drinks in them; psychotics who drink; homeless men who become drunk; criminals with a taste for liquor; or divorced people who occasionally tipple. People with liquor on their breath, no matter how frequently they are in trouble, cannot all be lumped under the convenient label of alcoholics. To ignore the many distinctions among drinkers is to invite practical objections from judges, police, or anyone else who must cope with these persons.

Psychiatrists, social workers, Alcoholics Anonymous, and others will be the first to protest that techniques which have proved successful with certain well-defined kinds of drinking problems are of little avail in others. While we shift slowly from the traditional attitude that drinking should be punished to the modern view that addiction to alcohol should be treated as an illness, we cannot free the sane drinker from legal or moral responsibility as if he were a victim of a virus. The drinker with a problem, as distinct from the problem drinker, is not suffering from a disease of alcoholism. If, in the paragraphs that follow, the portrait of alcoholism is not always in sharp focus, it is because so much confusion persists between the drinking problem and the problem drinker. But a modern program for dealing with alcoholism, as well as with other social problems associated with drinking, will help public health and legal institutions to refine their concepts and tailor their practices to the patient.

Alcoholism, in the sense that it is an obses-

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sion, is a major social tragedy. Compulsive in character, progressive in its damage to the alcoholic, his family, and the community, it exacts a costly toll. In "skid row" sections, in courts, jails, and city hospitals, we find the visible alcoholics, about 20 percent of the total number. The invisible majority, with no record of arrests or hospitalization, are hidden in offices and homes. Most of these refuse to acknowledge their condition, even to themselves, until the very last stages.

In penthouse or slum, the affliction strikes both genius and dullard, male and female (6 men to 1 woman). Most of the male alcoholics are in the prime of life, 85 percent being between the ages of 35 and 55. The alcoholic's life is curtailed by 2 to 12 years. The incidence of divorce is much above normal; 16 percent of the married male alcoholics are divorced and 25 percent separated. In New York City magistrates' home term court, 70 percent of the cases involve excessive drinking (*2*).

Alcoholism's annual toll of wage loss is estimated at half a billion dollars. The National Safety Council considers $120 million alcoholism's annual contribution to preventable accidents. Attributable relief costs are $22 million. Hospitalization for injuries and incarceration cost $56 million. A good guess of the total enormous private and public cost to victims and society is well over a billion dollars a year (*3*).

Nevertheless, few States or cities have laws or procedures that provide for treatment and rehabilitation of the compulsive drinker. In trouble, his usual fate is a term of "reform" in prison. Medical and social advances toward substituting treatment for punishment of problem drinkers have not been matched in politics and in the law.

It is hardly practical to look upon prison to "reform" the parade of drunkards that passes before a police court. Park benchers, alms solicitors, and disorderly persons as well as workingmen on a spree may be among the derelicts. Honest seamen temporarily on the beach and out-of-work longshoremen mingle with hopeless down-and-outers and periodic dipsomaniacs. Indiscriminate suspended sentences or short jail terms are futile for the chronic alcoholic. It is impossible even to separate the celebrators from the addicts. The defendants come before the judge in such numbers that he may not have time even for routine questions. As a first step, we need screening facilities to determine which defendants are in need of medical care and hospitalization. Adequate information, obtained before arraignment, would give judges information for proper disposition of cases. By such a procedure, confirmed alcoholics may be taken off the streets and committed to an institution for treatment if the legal mechanism for commitment is available and the legal criteria for commitment satisfactory.

The Hart Island Experiment

In a short-lived attempt to establish in August 1950 on New York's East River a place where a defendant might come for rehabilitation on a voluntary basis rather than go through the court's revolving door, New York City had a partial screening process. Here a special institution for handling homeless men whose problems were largely those of the indigent alcoholic was being created. These unfortunate people could voluntarily seek welfare department rehabilitation at Hart Island in preference to a correction department's jail. There was no compulsion to stay for any specified time. But one who left in less than 10 weeks could not return, and a suspended sentence might be executed. Medical care (including free eyeglasses and dentures when necessary), religious guidance, social therapy, Alcoholics Anonymous aid, vocational training, and job placement service were accorded to all. The rehabilitation program was humane, effective, and economically administered. It was a fruitful alternative to costly, barbaric, and useless successive jail sentences for those "offenses" which is society's label for the illness of alcoholism. Everybody had to work, selecting his job from the hundred or more work assignments for the operation and maintenance of the institution. Carpentry, electrical, laundry, kitchen, and dining room skills were on the way to being revived. With alcohol unobtainable, work to do, good food, recreation, and companionship, a change was soon noticeable. Weekly meetings of Alcoholics Anonymous helped in the struggle.

Resident employment counselors were there to obtain job referrals.

Since homeless men, such as those at Hart Island, rarely seek treatment and are afraid of being questioned, they are difficult to study. Accordingly, there is little scientific information about them as a group and their relation to alcohol. It was the recognition of this factor that led to the solicitation of the cooperation of the Yale Center of Alcohol Studies, which established a pilot study on the island.

The Yale center was not able to complete its work, for in the summer of 1954, because an increase in crime was held to require more jail space, Hart Island was overnight taken away from the New York City Department of Welfare and given to its Department of Correction. Thus, this potentially useful project ended before it was really on its feet. Whatever the needs of the correction department, the action eliminated a hopeful step in the treatment of alcoholism in New York.

In less than a 4-year period the widely heralded experiment at Hart Island appeared to offer a constructive approach. Since the experiment seemed to be sound in conception and efficient in operation, the Hart Island facilities were to be extended to include those who were not homeless but were willing to pay for rehabilitation there. It had been planned also to seek a State grant and a city budgetary appropriation for the creation of a halfway house to break the transition from the protected life at Hart Island to the competitive problems faced by the "alumni." This halfway house was to provide meals, lodgings, and recreation at cost in a controlled resocialization project until the Hart Island "graduate" had had a reasonable time to become secure in a newly achieved self-reliance—a self-reliance mixed with a dependence on an institutionalized way of life from which he must be freed at an individual pace. The Hart Island experience, as well as a somewhat similar project for study of homeless men sentenced to the Monroe County jail (conducted by the University of Rochester sociology department), might have provided the evidence needed to guide and obtain legislation for civil commitment to other nonpenal treatment facilities for wider varieties of the alcoholic sick.

This is the background to the note of disappointment implicit in the report of the New York State Bar committee. To explain that disappointment further, it is useful to make a brief survey of the history of legislation on the subject in New York.

Legislative Steps

New York State's progress toward enacting a sound alcoholism program has been slow. The penal law in force in 1897 provided: "Any person intoxicated in a public place is guilty of a misdemeanor, and may be arrested without a warrant while so intoxicated." In 1911, the words "is guilty of a misdemeanor" were deleted, eliminating such offenses from a category of "crime" (*4*). However, these persons were still subject to arrest in a lesser category of offense, such as disorderly conduct that annoys others. In order to resolve any ambiguity, the New York State Legislature amended the penal law in 1955 to provide that a person intoxicated in a public place may be arrested without a warrant while so intoxicated. If the charge is sustained and the person found guilty, he is deemed to have committed an offense. The amendment (ch. 823, L. 1955) makes proof of annoyance to others unnecessary. The arrest gives the magistrate original jurisdiction. But the problem still is what to do with an alcoholic when he comes before the judge.

In 1910, the inferior criminal courts act gave New York City the power to establish a board of inebriety and hospital and industrial colonies for the publicly intoxicated. In 1911, the State's general municipal law (secs. 136–139b) provided for boards of inebriety by localities outside of New York City. These sections have just been repealed (ch. 133, L. 1955) since no city operated such a colony, and the administrative provisions of the law are out of date.

In 1911 at Warwick, a hospital and colony was established by the New York City Board of Inebriety. With the enactment of prohibition in 1920, the board was abolished and the colony closed. The board's first report was the only one filed. Its functions were transferred to the New York City Department of Correction, again a step back to punishment. That department has taken no action except to receive

at Riker's Island some alcoholics sentenced there on a variety of charges.

New York's education law (sec. 804) provides for the compulsory teaching in schools of alcohol's evil effects. Its mental hygiene law (sec. 201) permits a judge of a court of record to commit an "alleged inebriate" to a private licensed institution for mental disorders on application of his family, a relative or friend, an officer of a charitable institution, a public welfare officer, or the inebriate himself. The physician in charge of the institution must present his consent in writing. In addition two examiners must certify that the subject is incapable of conducting himself or his affairs properly or is dangerous to himself or others by reason of frequent drunkenness, whether induced by alcohol or drugs or other intoxicating substances. The certificate must show that he is in actual need of special care and treatment and that his condition is such that his detention, care, and treatment would be likely to effect a cure. The section provides that a person so certified or a relative or friend may, within 30 days, apply for a review of the order of certification to the State supreme court. A jury then passes upon his inebriety. Private institutions have been unwilling to assume the responsibility for consenting to such commitments for fear of false-imprisonment suits. In addition only the rich could afford the cost of institutional care.

Under the present New York State law only psychotics may be retained and treated in State mental hygiene institutions. Haggard and Jellinek (*5*) have defined psychosis as insanity or mental disease. They report that only a small proportion of men who drink to excess develop alcoholic psychosis. Although psychosis is not a common occurrence in chronic alcoholism, certain changes in personality which cannot be called insanity do eventually occur in most chronic alcoholics. The authors state that in about 1.5 percent of chronic alcoholics the deterioration of conduct becomes complicated by uncontrolled rages, delusions, or other disturbing symptoms. The condition is then designated as chronic alcoholic deterioration with psychosis. The psychotic inebriate is segregated in mental institutions, and in that way society takes care of him. But the nonpsychotic inebriate at present gets attention from society only when he comes into conflict with the law. It is his illness which presents us with our primary challenge.

The world has been slow to consider the chronic alcoholic as a sick person. It has been slower still to concede that the alcoholic does not voluntarily choose the road to ruin. When the problem became acute, some localities "solved" it by jailing, some by exiling to other communities, and others by closing their eyes to the existence of any problem. From time to time, public opinion became aroused over these illusionary "solutions" and demanded action. It disturbed the community that arrest and jail were so expensive in money and lives. Finally, came a realization that here was a social problem better dealt with by appropriate social agencies than by police and prison. It was the social effects of alcohol that brought about the recognition of the need for committing alcoholics to treatment clinics rather than to jail.

In December 1948, the first clinic was established at the University of Buffalo, and the Edward J. Meyer Memorial Hospital set aside 20 beds for the treatment of alcoholic patients.

Through the efforts of the Medical Jurisprudence Committee of the Association of the Bar, the New York County Medical Society, and the New York City Academy of Medicine, the Rosenblatt bill was introduced in January 1949 providing a full-scale program. It called for the establishment of a bureau of alcoholic rehabilitation in the New York State Department of Mental Hygiene to study the causes, extent, prevention, control, and treatment of alcoholism and the rehabilitation of chronic alcoholics. To be established and equipped were hospitals, clinics, and custodial institutions or farms either in connection with other facilities for the diagnosis, classification, hospitalization, confinement, and treatment of alcoholics or independently. The bill also provided for the voluntary admission of alcoholics and the civil commitment of alcoholics to approved institutions by the courts. It was not reported out of committee.

In October 1949, the same groups proposed a bill creating a New York State Commission on Alcoholism along the lines of the Connecticut State Commission, directed to establish and operate information centers and clinics and to

arrange with existing hospitals to receive alcoholics for short-term treatment. It also provided a simple procedure for voluntary admissions and court commitments of alcoholics to hospitals, to the commission itself, and to members or groups of Alcoholics Anonymous. This bill was never introduced. Some objected that extensive additional facilities for long-term commitment of alcoholics were needed. So further time was wasted.

In 1952, the same interested groups retreated to the position of requesting simply a temporary commission to study the problem and report to the legislature. This time the objection was that the subject had been investigated enough and what was needed now was action. Finally, on March 31, 1952, a first step was achieved in the enactment of the Mitchell-Ten Eyck bill, ch. 354, L. 1952. It provided that the Commission on Mental Health in cooperation with the State departments of health and mental hygiene formulate a program to provide for the diagnosis, treatment, and rehabilitation of chronic alcoholics by public and private community agencies and authorized a study of the problems relating to alcoholism in conjunction with such a program. Appropriations aggregating $145,000 were made to carry out the purposes of the bill—$100,000 for services and $45,000 for research.

Under this bill the local government has primary responsibility for initiating and operating the services on a matching 50-percent basis for the cost of operation. The State supplies in addition consultant and supervisory services.

New Clinical Services

Modest progress has been made in setting up a number of outpatient clinics under the program, but these are not open to voluntary patients. The University of Buffalo Alcoholic Rehabilitation Center, opened in 1948 as previously mentioned, expanded its work under the program in association with the Meyer Memorial Hospital. Another clinic, in addition to the one opened in 1949 at the Rochester Health Bureau, was established in the Rochester City Hospital. The University of Rochester sociology department is making a penitentiary research study of men committed to Monroe County jail. New clinics were set up in Syracuse, in Binghamton, at the New York State University College of Medicine on Long Island, and in the home term court of the New York City magistrates' court. Further clinics in New York have been proposed.

Under the dollar matching by local resources, New York State's expenditure for clinical services from March 1952 to March 1954 was $42,499; an additional $27,305 was spent for research and administration. The 1955 allocation for services is $69,303 and for research, $39,458. It is possible that too much of the clinical service is research-motivated, but, if so, that is in line with the purposes of the legislation.

Recommendations

In the light of this history, the New York State Bar Association's committee report, which evoked this discussion, recommends: (*a*) that the State's program be expanded and accelerated; (*b*) that hospitals be encouraged to provide treatment facilities, medical schools provide research and training, and qualified medical personnel participate in and advance the program in closer cooperation with voluntary agencies for group therapy; and (*c*) that a keener awareness be aroused in local governments and health institutions concerning their responsibility for establishing and operating adequate facilities for rehabilitation.

For those who seek more specific guidance, these are the recommendations offered in 1947 by the Research Council on the Problems of Alcohol:

1. Problem drinkers suffering acute physical or mental damage should be admitted to general hospitals, mental hospitals, or other institutions.

2. Mental hospitals should accept directly or by referral from general hospitals symptomatic problem drinkers, that is, the psychotic. Farms and industrial colonies should be established for seriously deteriorated problem drinkers who have physical or mental damage.

3. Custody and care of alcoholics should be transferred from the police to public health agencies.

4. Facilities for treatment should be estab-

lished in the hospitals affiliated with medical schools so as to permit research and training of personnel.

5. Thoroughgoing research should be made into the causes, mechanism, and possible cures for alcoholism.

Support is warranted especially for the following recommendations of the New York State Bar Association: arrest, treatment, or punishment where over-use of alcohol is a factor; examination of the relationship to automobile accidents of over-use of alcohol by driver and pedestrian; acceptance of insurance companies of alcoholism as an insurable risk; more public education.

The New York State Bar Association attributes a want of fulfillment in the field of alcoholic rehabilitation to lack of medical interest and a failure of localities to initiate badly needed facilities. But the legal profession shares responsibility for a solution with every other available profession, organization, or agency, State and local, government and private. The failure to move cannot be ascribed alone to the local section for "a heavy share in the snail's pace of the attack on alcoholism." If New York City must accept full responsibility for the Hart Island action, so, also, must State legislators, hospitals, and physicians acknowledge their own obligations. The State's function must be spelled out. Selden D. Bacon says (*6*): "That the State has a responsibility to fulfill in the control of alcoholism as an extensive public health problem is a belief which has spread widely in recent years." This should not be open to question however broad may be the disagreement on the legislation proposed.

There appears to be a broad distribution of obligations of leadership in government. In the first instance, the State may bear the duty of legislating a full-scale program, although in many States the leadership may come from a few progressive towns. Whether or not they exercise initiative and leadership, cities and counties share in building a program. When State legislation is enacted, the localities can do their part more readily. The cost may be shared but that does not relieve the State of developing leadership which is centralized and firm rather than haphazard and dependent upon the uncertain direction in which individual localities move. In this social program, society is equated with the State. Many States have accepted such responsibility, going from simple surveys to well-established programs. Examples of well-integrated programs are found in Connecticut, Virginia, and Wisconsin.

10-Point Program

As a basis of discussion, the following 10-point program is offered with particular regard for the potentials of a rich State with broad resources.

1. Set up screening facilities in classification centers staffed by physicians, social investigators, probation officers of local departments, welfare workers, correction and police officers, and court officials. Start here. Identify. Examine. Diagnose. Give the data to the judge. Screen out the chronic alcoholics and take them off the streets and into institutions.

2. With the aid of screening material, the judge could usefully release some on probation on condition that alcoholics with a chance of rehabilitation go to the outpatient clinics such as those established under New York's Mitchell-Ten Eyck law. Make these clinics available to persons voluntarily seeking help and correlate them with the screening facilities.

3. Activate institutions such as the short-lived experiment at Hart Island.

4. Educate personnel in correctional institutions about the handling and treatment of alcoholics through inservice training programs and select more specialized personnel.

5. Set up a followup system to reduce jail repeaters. Cooperation among public health authorities, the Salvation Army, and Alcoholics Anonymous may save duplication in this respect. This system will provide case histories for screening facilities for clinics and courts.

6. Establish public farms on a self-supporting basis. They are cheaper than urban jails. Those who can afford it should go to private farms. Many States have established such farms with State and local aid. Although this point is the center of much controversy, my personal conviction is that the system is valid.

It seems to me that farms and industrial colonies are essential for seriously deteriorated problem drinkers and those needing long-term treatment. California has established a State colony. The Hart Island colony of New York City's East River was showing success. Although the Connecticut farm was closed in 1941, the report to the governor declared the idea sound (*6*).

Such institutions have distinct advantages. They isolate patients from congested areas; they eliminate the possibility of running down local metropolitan sections; they have a lower capital and operating cost than county or city jails or hospitals; they provide better moral and physical rehabilitation possibilities; and they afford opportunities to revive farm and other skills.

Haggard and Jellinek (*5*) state, "Hospitals or farms for inebriates must be equipped to classify the various types of inebriates according to the causes of their condition." Hirsh (*7*) says, "When we have learned to utilize our present facilities we might then go on and consider the construction of new ones, such as farms and industrial colonies for seriously deteriorated drinkers who present special and particularly severe problems of treatment and rehabilitation."

7. Empower judges to deal with persons having an alcoholic problem beyond their control under a civil rather than a criminal statute. Even rehabilitation-minded magistrates are now handcuffed to penal statutes.

8. Ultimately there must be a civil commitment procedure. When colonies or farms are set up, procedures can be established for commitment to these institutions on a voluntary and involuntary basis. Many States have commitment laws. In 1951, Georgia provided for both voluntary and involuntary commitment of alcoholics for treatment. In Connecticut, the probate court may commit a habitual drunkard or dipsomaniac or persons so addicted to the intemperate use of narcotics or stimulants that they have lost the power of self-control. California law allows commitment of alcoholics who are unable to transact ordinary business or who endanger themselves or so impoverish themselves as to require charitable aid or who are in danger of becoming degrading or detrimental influences upon their families or others. The longest, most successful program and the best facilities for dealing with the program and treating the alcoholics are found in Sweden, where there are places for voluntary treatment and for court commitment.

For New York State, the principle of compulsory commitment of alcoholics to privately licensed institutions was affirmed under section 201 of the mental hygiene law. But principle is not practice. The principle of commitment should not depend on ability to pay the high cost of private treatment. Nor should it be thwarted by the private institution's legitimate fear of a suit for false imprisonment.

9. We know what to do. Bridge the gap between what we know and what we do. Should expense be thrown up as a blockade to action, money must be provided by imaginative budget makers. Many States have done it, some by allocating a percentage of liquor license fees to separate administrations for rehabilitation.

10. In the meantime, general hospitals must admit drunkards suffering acute physical or mental damage. Mental hospitals must accept psychotic problem drinkers.

The legal and health system of the State must be prodded into accomplishment so that it will not fail in this crucial problem. We must care to cure.

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